FORM 109

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 109
600 Washington Street – 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA Board #
(If Known):

NOTIFICATION OF WITHDRAWAL OF CLAIM OR COMPLAINT

DO NOT USE THIS FORM TO INDICATE CHANGE OF COUNSEL. PLEASE USE FORM 114 FOR THAT PURPOSE.

1. Party Filing this Form is:

Insurer ☐ Employee ☐ Employee's Attorney ☐
Third Party (Describe: Physician, Hospital, Medical Vendor, Lien Holder) ☐

_____

2. Employee's Name (Last, First, MI):	3. Employee's Social Security Number*:
4. Employee's Address (No. and Street, City, State, Zip Code):	5. Employee's Telephone Number:
6. Name & Address of Employee's Attorney:	7. Telephone Number of Employee's Attorney:
	8. Date of Injury (mm/dd/yyyy):

9. Employer's Name & Address (No. and Street, City, State, Zip Code):

10. Insurer's Name & Address (No. and Street, City, State, Zip Code):

11. Withdrawing From:

- ☐ Claim for Benefits
- ☐ Complaint for Modification or Discontinuance
- ☐ Third Party Claim
- ☐ Claim for Illegal Discontinuance
- ☐ Complaint for Recoupment
- ☐ Other (specify)_____

12. Preparer's Name & Address (No. and Street, City, State, Zip Code):

13. Preparer's Signature ("On-File" is NOT acceptable, must have signature.):	**14. Date Prepared (mm/dd/yyyy):**

***Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents.**
Please Print Clearly or Type. Unreadable forms will be returned.